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Suicide Late in Life

There are few events that so deeply affect survivors as does suicide. Disbelief, anxiety, sadness, guilt, and deep questioning of one's prior relationship with the departed commonly follow the event. Virtually everyone closely associated with the person asks, "Could I have done anything to prevent it?"

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By Richard E. Finlayson

Suicide can be discussed from many perspectives—its prevalence, social and cultural antecedents, clinical risk factors, warning signs, and means of prevention. Addressing the topic from the standpoint of age reveals some notable findings. Most of the literature on the subject reveals that, in general, the rate of suicide increases with age. Gender also plays a role. The profile of a typical suicide victim in the United States is that of an *elderly single or widowed male, living alone and having serious chronic illness*. The presence of depression and or substance abuse problems further increases the risk. If that person has engaged in self-harm, for example, a suicide attempt in the past, the risk is further increased.

About ten to twelve people in 100,000 of the general population commit suicide each year in the United States. White males age sixty-five and over have a rate of about forty per 100,000. Rates for white women, black men, and black women are lower, with the latter being the lowest. Why do people make this very final tragic decision? What emotions lie behind the act? A study from Duke University Medical Center found an association between feeling guilty, sinful, or worthless and having suicidal thoughts.[1] The underlying causes of such feelings vary. The presence of major depression is probably the most powerful risk factor. If psychotic thinking enters the picture, the afflicted individual tends to lose his or her sense of reality and is less easily persuaded to accept treatment. For example, it is quite common for depressed older persons to experience delusions of poverty. A story that I have heard multiple times over the years here in southern Minnesota is that of a farmer who becomes depressed in the early spring and develops a belief that he is financially ruined and there is no reason to plant a crop. This belief typically contradicts his real circumstances, but he can't, in some cases, be persuaded to the contrary. Close family members usually bring the depressed person in to see the doctor rather than the person seeking the help himself. In this and cases

like it, the negative, distorted thinking is what drives the suicidal thoughts. This person may have experienced crop failures or other financial setbacks in the past, making him prone to worry about such matters. Memory is often the source of the particular delusion. Women also are not immune to fears and delusions of this type. Many are left with inadequate financial support when their partner dies or because they were unable to save enough for their later years.

The sources of major depression may include a personal or family history of major depression, alcoholism or drug abuse, an illness such as cancer or stroke, or a major loss such as the death of a spouse. These are risk factors that can lead to depression, which may, in turn, lead to the suicidal thinking and, in some cases, the actual act of suicide.

Wishing to die does not, in itself, indicate that the elderly person is thinking about suicide. During my years of nursing home practice, I encountered many elderly people (typically women as they greatly outnumber men in that setting) who wished to die, and actually looked forward to that day, but gave no thought to suicide. The nursing staff would hear the patient say, "I wish I were dead, why can't I just die?" The doctor is called to talk to this "suicidal person." A typical remark I heard from the senior was, "Doctor, I have had a good life. My husband is gone now. My children and grandchildren are enjoying a good life. My health is poor. Every day is just a dull routine and I don't enjoy it any more. No, I am not going to kill myself. I can wait for God to take me. I'm ready any time." In many of these cases there was no convincing evidence of depression or other mental disorder. A recent study report from the Free University of Berlin, Germany addressed the issue of the wish to die in very old persons.[2] The community sample included 516 persons aged 70 to 105. One hundred and fifteen persons (21.1 percent of the sample) said that they wanted to die or felt life was not worth living. Fifty-four actually wanted to die. Thirteen of the fifty-four did not have a specified mental disorder. Eleven persons (two percent of the sample) had suicidal thinking. In all the latter cases, there was at least one specified mental disorder. One can see from the study that about eighty percent of the community sample did not have a wish to die or think life was not worth living. Of those who wanted to die, seventy-six percent had a mental disorder, and of those who had suicidal thinking, all had at least one mental disorder. Thus, although I gave an example of a person who wanted to die, but did not have a mental disorder, the numbers from the Berlin study suggest that careful assessment should be done in all cases of persons, of any age, who express a wish to die.

The legal issues surrounding suicide are complex and closely linked with the clinical aspects. The pivotal point on which many of the issues involved hinge is whether the suicidal person's faculties are distorted by a mental disorder. It is common knowledge that culture powerfully influences suicidal behavior. We have witnessed multiple examples of suicidal acts by terrorists. Some religions promise eternal paradise to those who give their life in the cause of their faith. In January of this year, a Chinese news service reported that five members of an outlawed religious group had set themselves on fire in Tiananmen Square. One of the men was fifty-four years old. The group members expected to go immediately to paradise after they died. Suicidal missions also occur in wartime. In many cases, it is deemed an honor to die in battle.

Marsha Norman has written a brilliant one-act play, *'night, Mother,* that deals with a suicide that is patiently thought out and announced beforehand. In the story, Jessie Cates, about 40 years of age, lives with her mother Thelma. On the fateful evening Jessie calmly announces to her mother that she is planning to kill herself (by gunshot) later that evening. A desperate struggle by Thelma to change Jessie's mind seems only to firm Jessie's resolve. Jessie has had a long struggle with illness and personal failures. The suicide happens. The reader or observer of the play must conclude that Jessie put a great deal of thought into the decision. One is not lead to think that she was impaired in her reasoning or reality testing. Although there are obvious ethical, philosophical, and religious issues implied by the play, one has a difficult time finding a legal toehold in the story. We can assume that suicides do occur, and will continue to occur, in the absence of mental illness as we have defined it, because of philosophical, religious, patriotic, and other reasons.

Legal and forensic issues do come into play in some cases of suicide by the elderly. A homicide-

suicide study of thirty-nine cases from Victoria, Australia, provided some data concerning those who were elderly.[3] It was noted that physical ill health and financial stress were important associative factors, especially in the elderly. This is consistent with other reports that indicated that financial problems and decreased functional ability are important factors in suicides per se. Murder-suicides tend to follow a different pattern in younger people. In my experience the motives are more likely related to feelings such as rejection and jealousy.

Perhaps the most controversial and debated issue related to suicide in our day is that of assisted suicide, typically physician-assisted suicide. Dr. Kavorkian's work is well known to the general public. It is important to note that many of his assisted suicides were not elderly, but did have serious physical disorders. This dispels the notion that the elderly are first in line for such services. We should remember, however, that the elderly represent only about twelve percent of the general population and could be underrepresented on that basis alone. They could be overrepresented on the basis of the rates of chronic diseases. A study conducted in the Netherlands did not support the suggestion that assisted suicide is mainly performed among the elderly.[4] The oldest man who underwent assisted suicide was sixty-two, and the oldest woman, sixty-five. Gerontologists of our day would consider these people to be relatively young or the "young old."

My experience with suicide in the elderly has been in the clinical realm, specifically psychiatric practice. This has included outpatients, inpatients, and nursing home residents. Consideration of the possibility of suicide was an almost daily event. Simon has stated, "The most common legal action involving psychiatric care is the failure to reasonably protect patients from harming themselves."[5] Simon goes on to observe that theories of negligence can be grouped into two broad categories:

1. Failure to properly diagnose (assess the potential for suicide), and
2. Failure to implement an appropriate treatment plan (use reasonable interventions and precautions).[6]

There is an old adage that the three most important things in medical practice are "diagnosis, diagnosis, and diagnosis." This is true because without a correct diagnosis there is less certainty that an effective treatment plan can be crafted. The two most important issues in diagnosis of the suicidal elderly person are assessing for the presence of a mental disorder, which may affect the individual's reasoning and reality testing, and understanding the potential for suicide. I have already mentioned the factors that increase risk, but I extend those comments to say that, in the assessment process, I have found the two most important to be the degree of hopelessness expressed and whether the person has formulated a plan with a chosen method. The availability of social support is very important for the safety of the person experiencing suicidal thinking.

In summary, suicide rates increase with age. Suicidal thinking and behavior in the elderly are most commonly associated with major depression. Additional factors placing the older person at risk of suicide are male gender, substance abuse, and chronic illness. Social support seems to reduce risk. The most prominent or active legal issues surrounding the topic of suicide at this time are that of professional responsibility to prevent suicide and physician-assisted suicide.

Endnotes

1. Thomas R. Lynch et al., *Correlates of Suicidal Ideation Among an Elderly Depressed Sample,* 56(1) J. AFFECTIVE DISORDERS 9–15 (1999).
2. M. Linden & S. Barnow, *The Wish to Die in Very Old Persons Near the End of Life: A Psychiatric Problem?,* 9(3) INT'L PSYCHOGERIATRICS 291–307 (1997).
3. Chris M. Milroy et al., *Homicide-Suicide in Victoria, Australia,* 18(4) AM. J. FORENSIC MED. & PATHOLOGY 369–73 (1997).
4. Bregje D. Onwuteaka-Philipsen et al., *Euthanasia and Old Age,* 26(6) AGE & AGEING 487–92 (1997).
5. ROBERT I. SIMON, CONCISE GUIDE TO PSYCHIATRY AND LAW FOR CLINICIANS (2d ed. 1998).
6. *Id.*